Supreme Court, U.S.
FILED

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No.

IN THE
# Supreme Court of the United States

KIRK TEDFORD,

*Petitioner*,

v.

BENCHMARK INSURANCE COMPANY AND THE FUTURE EQUIPMENT COMPANY, INC. EMPLOYEE WELFARE BENEFIT PLAN

*Respondents.*

**Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit**

## PETITION FOR A WRIT OF CERTIORARI

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35 pp

## QUESTION PRESENTED

In this case, the Fifth Circuit held, in conflict with decisions of the Second, Third, Fourth, Sixth, Seventh, Eighth, and Ninth Circuits that when an insurance claims administrator for an ERISA employee medical benefits plan denies coverage based on a factual determination, its factual determination is reviewable only for abuse of discretion – even where the claims administrator has not been delegated authority under the plan to make final and binding determinations. The case presents the following question:

Whether an ERISA plan participant is entitled to *de novo* review of an insurance claims administrator's fact-based decision to deny coverage for medical benefits when the claims administrator has not been delegated the authority under the plan to make final and binding determinations?

## RULE 14.1(b) STATEMENT

Pursuant to the Court's Rule 14.1(b), petitioner states that the parties in the court of appeals, who are respondents here, are Benchmark Insurance Company and the Employee Welfare Benefit Plan sponsored by Future Equipment Company, Inc., defendants-appellees.

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## PETITION FOR A WRIT OF CERTIORARI

Kirk Tedford respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

## OPINIONS BELOW

The trial court's opinion is included at App.8a - 25a. The court of appeals' opinion is included at App. 1a- 7a. The appendix is attached.

## JURISDICTION

The court of appeals entered judgment on June 17, 2002. This Court has jurisdiction under 28 U.S.C. § 1254(1).

## AND STATUTORY PROVISIONS INVOLVED

The pertinent provisions of the Employee Retirement and Income and Security Act of 1974 (ERISA) § 503, 29 U.S.C. § 1133; §3(16)(A)(ii) and (B), 29 U.S.C.1002; ERISA § 404(a)(1) 29 U.S.C. §1104; and ERISA §402(a) 29 U.S.C. § 1102 are included at App. 26a -27a, attached.

## STATEMENT OF CASE

**A. Facts**. On November 5, 1999, Kirk Tedford was injured in a motorcycle accident. As a result of a severe head injury, Tedford remained comatose for three weeks. On being discharged from Harris Hospital in early December, 1999, Tedford requested his medical bills be paid by his medical benefit plan. (R.941)[1]

**1. The Administrative Process**. Tedford was a participant in an employee welfare benefit plan sponsored

[1] "App. _ " references are to the attached appendix, and "R. __" references are to pages in the original five volume district court record prepared for the court of appeals.

by Future Equipment Co., Inc. (the Plan). Future Equipment purchased a group medical insurance policy underwritten by Benchmark Insurance Company (Benchmark), effective from June 1, 1999, to May 31, 2000. (R. 195) The Certificate of Insurance was issued to the Plan by National Heath Care Trust (Trust), a Mississippi Trust established by Corporate Benefit Services of America, Inc. (CBSA) as Trustor.

Benchmark also contracted with CBSA to adjust claims within written guidelines and parameters pre-approved in writing by Benchmark. CBSA received Tedford's hospital records on March 15, 2000. (R.784) The hospital bill was $173,755.56, and all medical bills totaled $229,329. (R. 303, 944) On March 21, 2000, CBSA denied coverage, claiming that at the time of the accident Tedford was intoxicated and using illegal drugs. (R.189) CBSA reached this conclusion based solely on a report in the hospital records that stated "ethyl alcohol" of "142H." The report stated that "this alcohol result is for medical purposes only. It is not a forensic order." Then, under "INTERPRETIVE NOTES" it indicated "100 mg/dl – may be intoxicated." (R. 334) The toxicology report also indicated "amphetamines-positives" and "opiates-positive." (R. 335) CBSA's denial of coverage rested on this Certificate provision:

> Benchmark shall not be liable for any losses sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(R.274)

On April 24, 2000, before the Benchmark policy terminated, Tedford appealed CBSA's initial decision denying coverage to CBSA, contending he had not

consumed opiates or amphetamines, and suggesting these were administered to him while he was unconscious. He also asserted he was not intoxicated, and that the accident was not a consequence of the consumption of alcohol. (R.617-19) Though CBSA never talked to or requested any further information from Tedford, it denied his appeal on July 22, 2000. (R.192-193)

**2. CBSA Was Not the Plan Administrator or Fiduciary.** Future Equipment purchased employee medical insurance for the Plan when it signed an EMPLOYER'S SUBSCRIPTION AGREEMENT, which provides:

> If approved, the employer understands and agrees that the trustee, administrator [CBSA] and the insurer [Benchmark], jointly or severally, are not now and shall not become under the Trust Agreement an administrator or fiduciary for any purpose whatever under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other law.

(R.195-196)

The CERTIFICATE OF GROUP INSURANCE the Trust issued to Future Equipment provides:

> By purchasing this coverage, an employer is establishing an Employee Welfare Plan, and may therefore be subject to compliance with the Employee Retirement Income Security Act of 1974 (ERISA). Benchmark, in performing its obligations under the policy, is acting only as a health insurer with respect to the policy and is not in any way acting as a plan administrator, a plan sponsor or a plan trustee for the purpose of ERISA . . . . The Administrator [CBSA], in performing its obligations under the terms of an

> agreement with Benchmark, is not acting in any way as a plan administrator, a plan sponsor or a plan trustee for the purposes of ERISA . . . .

(R.199)

The BENCHMARK GROUP MEDICAL INSURANCE POLICY, issued by Benchmark to the Trust, provides:

> Benchmark, in performing its duties and obligations under this policy, is acting only as a health insurer with respect to this policy and is not in any way acting as a plan administrator, a plan sponsor, or a plan trustee for the purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other federal or state law. The Administrator [CBSA], in performing its obligations under the terms of an agreement with Benchmark, is not acting in any way as a plan administrator, a plan sponsor or a plan trustee for the purposes of ERISA, as amended, or any other federal or state law.

(R.736) Neither Benchmark nor CBSA were named fiduciaries in the Plan documents, as required under 29 U.S.C. §402a (App. 26a), and Benchmark and CBSA three times expressly disclaimed that either would serve any role as the Plan administrator or fiduciary for purposes of ERISA.

**3. CBSA Was Not Delegated Authority To Make Factual Determinations or Approve Large Claims.** In the ADMINISTRATIVE AGREEMENT between Benchmark and CBSA, Benchmark expressly prohibited CBSA from approving a claim like Tedford's. CBSA and Benchmark's ADMINISTRATIVE AGREEMENT provides:

> Administrator [CBSA] shall process, investigate, settle and pay all valid claims, including expenses incurred in the investigation and settlement thereof, arising under Group Master Policy or Policies, subject to the supervision of the Company and in accordance with the terms and provisions of the Group Master Policy or Policies and guidelines recommended by Administrator and approved in writing by the company. All such claims shall be handled in a manner and under standards customary to the insurance industry and as required by applicable law. In addition, any single health claim payment in the amount of $10,000 to $24,999 shall be sent to the Company for review after being paid, while any single health claim payment in the amount of $25,000 or more shall require the Company's prior approval before being paid. For any claimant where the diagnosis is such to indicate that the total health claims cost may exceed $50,000, the situation shall be brought to the immediate attention of the Company when Administrator receives notice of that diagnosis.

(R.165-166)

These provisions do not delegate to CBSA the authority to "make an independent determination of the applicant's eligibility for benefits under the Plan [where] that decision 'shall be final and conclusive upon all persons if supported by substantial evidence'." *Wildbur v. Arco Chemical Co.*, 974 F.2d 631, 637 (5th Cir. 1992), *modified by,* 979 F.2d 1013 (5th Cir. 1992). No decision by CBSA approving Tedford's eligibility for benefits would be a "final determination binding" on Benchmark, who alone could approve Tedford's claim.

**B. The Judicial Proceedings Below.** Tedford filed suit in state court against Benchmark, which removed the case to federal district court in the Northern District of Texas. The parties agreed that all issues could be decided by the Magistrate. The Future Equipment Employee Welfare Benefit Plan was added as a defendant. Defendants moved for summary judgment, and Tedford filed a response and cross-motion for summary judgment. In his response, Tedford challenged the accuracy and sufficiency of the administrative record submitted by CBSA. He requested a *de novo* trial to establish whether CBSA's denial of coverage was correct. Tedford contended that no deference should be accorded CBSA's administrative decision denying the claim because CBSA was not the Plan Administrator, was not an ERISA fiduciary, and had not been delegated discretionary authority to make final and binding decisions of fact or plan interpretation. Tedford argued that CBSA's decision was entitled to no judicial deference because CBSA had no authority to approve Tedford's claim. Finally, Tedford contended that coverage could not be denied based on the evidence in the administrative record because Mississippi law, which was incorporated into the plan provisions, prohibited the use of hospital record test reports as a basis for denying coverage.

The factual reason CBSA gave Tedford for denying coverage under the policy was:

> According to the medical records obtained from Harris Methodist Fort Worth Hospital, Mr. Tedford's toxicology report of November 6, 1999 indicates a blood alcohol level of 142. By the hospital's own measures, blood alcohol levels in excess of 100 mg/dl means the patient may be intoxicated. This same toxicology report also

shows Mr. Tedford positive for opiates and amphetamines. Opiates are a synthetic narcotic.

(R.193) CBSA denied coverage under a Mississippi policy issued by a Mississippi Trust, which specified Mississippi law applied, solely on the basis of hospital test results of drug and alcohol concentrations, even though MISS. CODE ANN. §63-11-45 prohibited it from doing so.[2]

**1. The District Court's Decision.** The trial court recognized that *de novo* review of CBSA's decision denying Tedford benefits was required "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." (App. 11a) This result is dictated by ERISA § 503, which requires every employee benefit plan to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. §1133. (App. 27a) Even though CBSA had continually disclaimed any status as a

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[2]MISS. CODE ANN. § 63-11-45 provides:

> Denial of insurance coverage on ground of refusal to submit to test or upon basis of test results. No coverage otherwise afforded under any policy of insurance shall be denied on the ground that any person has refused any test provided for by this chapter nor on the basis of the results of any such test. Any provision to such effect in any insurance policy hereinafter issued shall be void.

MISS. CODE ANN. § 63-11-3(c) defines "such test" as any "chemical test" that is an "analysis of a person's blood, breath, urine or other bodily substance for the determination of the presence of alcohol . . . ." Those performing "such tests" include "emergency medical personnel, nurses and doctors." MISS. CODE ANN. § 63-11-3(f). A person can be convicted of DWI on such test results, but insurance coverage cannot be denied on the basis of such test results.

fiduciary under ERISA, the trial court concluded CBSA was a fiduciary, reasoning:

> The validity of these disclaimers is questionable at best, and in fact, the Defendants now assert that their own disclaimers are void. A disclaimer of the role of the plan administrator may be permissible because when no administrator is specifically designated by the plan, the plan sponsor becomes the plan administrator by statute. 29 U.S.C. § 1002(16)(A)(ii), (B). But attempts to renounce a fiduciary role do not appear to be authorized by ERISA. To the contrary, except in limited circumstances not applicable here, a provision in an agreement or instrument purporting to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under ERISA is void as against public policy. 29 U.S.C. § 1110(a). *Cf. Custer v. Pan Am. Life Ins. Co.*, 12 F.3d 410, 418 n. 3(4th Cir. 1993)(noting that contractual disclaimer of ERISA fiduciary status should not be determinative, discretionary functions performed should control).

(App. 12a) After declaring that the disclaimer of CBSA's fiduciary role was illegal and void, and even while acknowledging CBSA had no authority to approve Tedford's claim, the trial court applied the unique rule in the Fifth Circuit requiring deference to all factual findings of ERISA plan fiduciaries.

> Regardless of the discretion, if any, that the plan grants to its administrator or fiduciaries to interpret the plan terms, the Fifth Circuit holds that factual determinations under ERISA plans are to be reviewed under an abuse of the discretion

> standard. *Pierre v. Connecticut Gen. Life Ins. Co.*,932 F.2d 1552, 1562 (5th Cir. 1991), *cited in Bratton*, 215 F.3d at 523. The Fifth Circuit distinguishes *Bruch* as limited to matters of plan interpretation when the facts are not in dispute, and ruled that the federal courts owe due deference to factual determinations made during the benefit review process. *Bratton*, 215 F.3d at 522; *Pierre*, 932 F.2d at 1562. Because Tedford is contesting findings that are factual rather than interpretative in nature, an abuse of discretion standard is appropriate.

(App. 14a-15a)

The trial court's reasoning started with the major premise of the Fifth Circuit's rule first articulated in *Pierre*: If any plan fiduciary decides factual issues in denying benefit coverage, then its findings of fact are entitled to trial court deference and review under the abuse of discretion standard. The trial court then used this minor premise: CBSA decided factual issues in determining benefit coverage. Therefore, the trial court concluded: "In reviewing whether there has been an abuse of discretion, the court must analyze whether the plan administrator acted arbitrarily or capriciously in making his determination." (App. 15a). Under the *Pierre* rule, even where an administrator or plan fiduciary is not delegated any discretion to make factual determinations that are binding on both the plan and participant, Fifth Circuit courts defer to those factual determinations, and always review them under an abuse of discretion standard.

The trial court followed *Pierre*, deferring to what it characterized as the factual determinations of a plan fiduciary, even though CBSA was not delegated discretion to make final and binding decisions about claims

eligibility. *Pierre's* extreme consequence is illustrated by this case. Here, the insurer and its claims-adjustor made absolutely clear that neither was the Plan administrator or fiduciary for ERISA purposes. Then, the Benchmark agreement with CBSA made it impossible for the claims-adjustor to approve Tedford's claim unless the insurer approved it first. Nonetheless, the trial court felt constrained to follow *Pierre* and deny Tedford *de novo* review of CBSA's denial of his claim.[3]

How important *de novo* review was to Tedford is illustrated in the trial court opinion. Having invalidated the disclaimers, and having found "discretion" to deny Tedford's claim was delegated to CBSA, the trial court then took the next step dictated by Fifth Circuit law. *Pierre* required the trial court to review CBSA's decision under an arbitrary and capricious standard. The trial court noted:

> Because a decision whether an abuse of discretion has occurred is based upon information known to the administrator at the time he made the decision, the court is generally confined to the record available to the administrator when receiving the factual determinations underlying denial of a claims.

(App. 16a) This doctrine originates in the Fifth Circuit decision in *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 299 (5th Cir. 1999) *en banc*, which the trial court

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[3]CBSA was not delegated discretion to interpret the policy. Nonetheless, the trial court upheld the claims-adjustor's interpretation of the Certificate even though CBSA ignored the unambiguous policy provision incorporating Mississippi law which prohibits denial of insurance coverage based on alcohol or drug tests administered for medical purposes at hospitals.

cited. *Vega* restricts trial court review to the administrative record submitted to the court by the defendants. As the trial court noted, "The Fifth Circuit has directed the district courts to consider whether the record that was developed adequately supports the administrative determination." (App. 18a) Evidence outside CBSA's administrative record could not be considered.

The trial court, in applying the Fifth Circuit rules in *Pierre* and *Vega,* decided this issue: Did CBSA act arbitrarily and capriciously in denying Tedford's claim, based on the record it had assembled, recognizing it was under "no specific duty to conduct a reasonable or good faith investigation . . ." (App. 17a) The trial court concluded CBSA's denial of the claim was not arbitrary and capricious based on the record CBSA assembled, even while it acknowledged "the court agrees that the documentation is not a model of organization" (App. 20a) *and that CBSA's conclusion that Tedford used narcotics was false* because "Tedford was given several medications en route to the hospital (and before being tested), but CBSA either did not have this report or did not appreciate its import prior to denying Tedford's claim" (App. 19a).

Tedford requested *de novo* review. Had he prevailed it would have dramatically changed the issue the trial court would have to decide. Tedford wanted the trial court to decide whether the accident was a consequence of his intoxication or use of illegal drugs. That was not decided. Instead, the trial court decided that CBSA had included enough information, even if some was false, to preclude the court from finding CBSA had acted arbitrarily and capriciously in denying the claim, based solely on the administrative record CBSA assembled.

**2. The Fifth Circuit's Decision.**

The Fifth Circuit affirmed, incorrectly referring to CBSA as the plan administrator and ignoring that it had not been delegated interpretive authority with respect to the Plan. The Fifth Circuit implicitly took *Pierre* two steps further. Not only did the Fifth Circuit affirm the trial court's deference to a claims-adjustor's decision denying benefits where the plan did not delegate to the claims-adjustor either discretion to interpret the plan or to make final factual determinations, it did so even though (1) the decision-maker was expressly prohibited by its contract with the insurer from approving a claim as large as Tedford's and (2) both the decision-making claims-adjustor and the insurer expressly disavowed that either was the Plan administrator or fiduciary for purposes of ERISA.

## REASONS FOR GRANTING THE WRIT

This case presents an important issue covering the administration of ERISA over which the lower federal courts are irreconcilably divided, with the Fifth Circuit adhering to a position uniformly rejected by other circuits Both *Pierre* and the decisions below in this case, extending deference (1) of those who represent they are not plan administrators or fiduciaries, (2) where the decision-maker is not delegated authority to make binding decisions, but (3) is prohibited from doing so, should be reversed. Where the person or entity deciding claims eligibility is not a plan administrator or fiduciary for ERISA purposes, and is not delegated authority under the employee benefit plan to make final determinations about coverage, then the decision denying coverage should be entitled to no deference by trial courts. Reversing *Pierre* is all the more important when it is viewed in conjunction with Fifth Circuit doctrine set forth in *Vega,* that in

making a decision denying a claim, the decision-maker is under no duty to make a reasonable investigation of the claim, and a trial court cannot consider evidence relating to factual disputes other than such information as the insurer includes in its file upon which it relied in denying the claim. Trials in courts of factual disputes should be *de novo*, like any breach of contract lawsuit. Before this case, *Pierre* stood alone as an unfortunate anomaly. Now it has been carried to its extreme.

**I. The Fifth Circuit's Requirement that Trial Courts Review All Factual Decisions Under The Abuse of Discretion Standard Conflicts With Decisions in Six Circuits, Which Apply the *De Novo* Standard of Review Unless the Plan Expressly Grants Discretion to a Fiduciary to Make Final and Binding Factual Determinations.** The Fifth Circuit alone holds that even where the employee benefit plan does not delegate to the plan administrator or fiduciary the discretion to make factual determinations about benefit eligibility, the trial court nonetheless should defer to the factual findings of the decision-maker, reviewing the decision under an abuse of discretion standard rather than *de novo*. *Pierre v. Conn. Gen. Life Ins. Co.*, 932 F.2d 1552 (5th Cir. 1991) *cert. denied* 502 U.S. 973 and *Estate of Bratton v. National Union Fire Ins. Co.* 215 F.3d, 516 (5th Cir. 2000). The dissent from the denial of certiorari in *Pierre* by Justices White and Blackmun noted a conflict between the Fifth Circuit decision and the Third Circuit decision in *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991), the Fourth Circuit decision in *Reinking v. Philadelphia American Life Ins. Co.*, 910 F.2d 1210 (4thCir. 1990), and by *dicta* the Seventh Circuit decision in *Petrilli v. Drecksel*, 910 F.2d 1441, 1446 (7th Cir. 1990). *Pierre*, 502 U.S. at 973.

In *Luby, supra*, at 1183, the Third Circuit, three months after *Pierre* was decided, rejected the Fifth Circuit's position, noting:

> We are likewise not convinced by the [*Pierre*] rationale . . . holding that administrator's factual determinations should be subject to deferential review. Plan administrators are not governmental agencies who are frequently granted deferential review because of their acknowledged expertise. Administrators may be laypersons appointed under the plan, sometimes without any legal, accounting, or other training preparing them for their responsible position, often without any experience in or . . . little knowledge of the rules of evidence or legal procedures to assist them in fact finding.

Since the Court denied certiorari in *Pierre*, the rejection of the *Pierre* doctrine by the other Circuits has intensified. In addressing *Pierre*, the Seventh Circuit said: "We do not agree with that court's conclusion because *Pierre* is fundamentally inconsistent with Trust law" and "inconsistent with the Supreme Court's rejection in *Firestone* of the argument . . . ." *Ramsey v. Hercules, Inc.*, 77 F.3d 199, 204 (7th Cir. 1996). Other points in *Pierre* that the Seventh Circuit found "similarly unpersuasive" included the Fifth Circuit's "assuming administrators are unbiased fact finders like the courts" and the "fear of a flood of litigation . . . ." *Id.* at 205.

In *Dvorak v. Metro. Life Ins. Co.*, 965 F.2d 606, 609 (8th Cir. 1992), the Eighth Circuit rejected the insurer's request that the court show deference to the insurer's decision even though the plan did "not give Metropolitan the requisite discretionary power" that would call for judicial deference. *See also, Donatelli v. Home Ins. Co.*,

992 F.2d 763, 765 (8th Cir. 1993); and *Riedl v. Gen. Am. Life Ins. Co.*, 248 F.3d 753, 756 (8th Cir. 2001) ("We hold that absent language in the plan granting discretionary authority to the administrator to determine eligibility for benefits or to construe the terms of the plan, fact-based determinations should receive *de novo* review.")

The Ninth Circuit rejected *Pierre* in *Walker v. Am. Homeshield Long Term Disability Plan*, 180 F.3d 1065, 1069-70 (9th Cir. 1999), stating: "[W]e acknowledge but disagree with the Fifth Circuit's view in *Pierre*" and holding "that *Firestone* did not leave open the issue of whether factual determinations should be reviewed under a different standard than plan interpretations."

In *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 250-51 (2d Cir. 1999), the Second Circuit disagreed with *Pierre's* holding that *de novo* review does not apply to fact based determinations in the absence of plan language granting discretionary authority. The Sixth Circuit has also followed the other Circuits in not adopting *Pierre*. *Delk v. Ford Motor Co.*, 96 F.3d 182 (6th Cir. 1996), *cert. denied*, 520 U.S. 1275 (1997). *See also Rowan v. UNUM Life Ins. Co. of Am.*, 119 F.3d 433, 435-36 (6th Cir. 1997). Several district courts in the First Circuit have rejected *Pierre*. *See Cleary v. Knapp Shoes, Inc.*, 924 F.Supp. 309, 313 n. 5 (D. Mass. 1996); *Jorstad v. Conn. Gen. Life Ins. Co.*, 844 F.Supp. 46, 54 (D. Mass. 1994); and *Grady v. Paul Revere Life Ins. Co.*, 10 F.Supp.2d 100 (D.R.I. 1998).

*Pierre* has been expressly rejected by courts in the First, Second, Third, Fourth, Sixth, Seventh, Eighth, and Ninth Circuits. Unfortunately, the trial court in this case was bound to follow *Pierre*, and deferred to the claims-adjustor's decision denying coverage even though no

language in the Plan delegated such authority to CBSA, and even though the agreement between CBSA and the insurer denied the claims-adjustor authority to approve Tedford's claim. The Fifth Circuit's rote affirmance reflects its rigid adherence to the rule despite its uniform rejection elswhere.

**II. *Pierre* Thwarts the Goals of ERISA.** ERISA was intended to provide federal assurance that employees who are promised benefits get them. To ensure this, ERISA § 404(a)(1) provides that "a fiduciary shall discharge his duties with respect to the plan solely in the interests of participants and beneficiaries and for the exclusive purpose of providing benefits to participants and beneficiaries." 29 U.S.C. § 1104. ERISA § 503 requires that the Plan provide the employee whose benefit claim has been denied the right to appeal that decision "for a full and fair review by the appropriate named fiduciary . . . ." 29 U.S.C. § 1133. The fiduciary should put the interests of the employees before its own or the insurer's interests. How far ERISA falls short of this goal in the Fifth Circuit is illustrated in this case.[4]

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[4]Lorraine Schmall, *Toward Full Participation and Protection of the Worker With Illness: The Failure of Federal Health Law After McCann v. H&H Music Co.*, 29 Wake Forest L.R. 781 (1994):

> Existing laws are ineffective to ensure that the worker with illness has adequate health care coverage. ERISA and other potential sources of federal statutory protection of the ill or disabled employee . . . fail. Absent a clear statutory mandate to the contrary, the courts have been content to defer to the business judgment of the plan trustee, and to construe provisions against protection. The result is often catastrophic for the worker, resulting in loss of coverage and loss of job, if not total destitution from

ERISA was passed to protect employees.[5] Under ERISA, a fiduciary is required to fairly decide when claims should be paid. ERISA is silent on how disputes concerning benefits should be resolved. Consequently, the courts decided the procedure for claims review. When disputes about benefit eligibility arose, plan sponsors, under employer established and administered plans, were analogized to trustees of a trust fund, who protect the corpus as well as pay the beneficiaries under the plan provisions. If the trust instrument authorized the trustee to make discretionary determinations about the proper interpretation of the trust instruments and to decide benefit eligibility, courts were reluctant to second guess those decisions, absent proof of abuse of discretion. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court applied principles of trust law to decisions on benefit claims where the trust instrument expressly provided the fiduciary-administrator with

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impossibly high bills.

[5] Alison Rozbruch, *Resolving the Conflict Between Two Visions For A Standard of Review In ERISA Denial of Benefit Claims*, 9 J.L. & Pol'y 507-508 (2001):

> "Congress enacted ERISA in 1974 after a decade of work on pension and employee benefit issues." ERISA's stated purpose is to uniformly protect "the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by proving for appropriate remedies, sanctions, and ready access to federal courts." Although the Act purports to protect participants, judicial decisions continually interpret ERISA as a shield for employers, insurance companies and plan administrators.

discretionary authority to decide benefit eligibility within the terms of the trust.[6]

The Fifth Circuit in *Pierre* incorrectly applied *Firestone* in requiring deference to factual determinations made by fiduciaries, even though the terms of the Plan did not grant the decisionmaker authority to make final and binding factual determinations. This Court recently stated that its decision in *Firestone* "recognized that an ERISA plan could be designed to grant 'discretion' to a plan fiduciary, deserving deference from the court reviewing a discretionary judgment . . . ." *Rush Prudential HMO, Inc.*

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[6] Jay Conison, *Suits For Benefits under ERISA*, 54 U. Pitt. L. Rev. 1, 58 (1992):

> The Court's assumption that benefit suits are review proceedings appears to be yet another case of blind adherence to received tradition. This is most unfortunate. A review proceeding is one for the correction of errors. It is not a proceeding for the original determination of facts or rights and necessarily is more limited than the proceedings to be reviewed. Its scope will depend, possibly in large part, on considerations other than ascertaining truth or settling a dispute. In particular, it will depend on institutional considerations, such as the respective roles and competencies of the initial and reviewing decisionmakers, and the need for efficiency and fairness in the system. By requiring suits for benefits to be treated as review proceedings, the Supreme Court required their form and scope to be guided by considerations other than the correct determination of benefit entitlement. Yet by failing to identify the policies and considerations that might properly determine that character of review, the Court invited indiscriminate reliance on non-ERISA considerations.

*v. Moran*, 122 S.Ct. 2151, 2002 U.S. Lexis 4644, 50 (2002). But "ERISA itself provides nothing about the standard" much less "directly providing a lenient standard for judicial review of benefit denials . . . ." *Id.* at 52 The Fifth Circuit, in this case, elevated deference to an Eleventh Commandment, requiring claimants to prove that a claims-adjustor's factual decision was an abuse of discretion even where the Plan granted no discretion to the claims-adjustor, the insurer contractually prohibited the claims-adjustor from approving the claim, and the claims-adjustor insisted it was not an ERISA fiduciary or Plan Administration.

Today, most employers offering funded welfare benefit plans do so by purchasing insurance. Employees usually pay part of the insurance premiums. The Future Equipment Plan required employees pay 25% of the premium for coverage, 35% for their dependent coverage. (R.195) The Department of Labor, Bureau of Labor Statistics,[7] reports that from 1988 to 1997, the percent of employees of medium and large private employers who were covered by medical care fee-for-service plans, which would include employer funded and administered plans, fell from 74% to 27%, while employees covered by HMO's increased from 19% to 33%, and employees covered by preferred provider organizations increased from 7% to 40%.[8] During that period, the employees who

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[7]U.S. Dept. of Labor, Bureau of Labor statistics, Employee Benefits Survey, available at http://data.bls.gov/cgi-bin/survemost.

[8] The Benchmark policy was a Preferred Provider Plan, with a $500 deductible providing 80/60% coverage with co-pay, which means 80% payment for those in the PPO group, 60% payment if not. (R.196)

were required to contribute toward the cost of their medical care benefits increased from 44% to 69%. By contrast, from 1992 through 2001, private employers' contributions to healthcare benefits declined from 6.3% to 5.6% of employees' total compensation.

Though the work-world has changed, ERISA has not. Employees are not treated as insureds under insurance policies; instead the trust analogy still applies, resulting in insurers and their claims-adjustors *ipso facto* being deemed fiduciaries, their own disclaimers notwithstanding, vested with discretion to decide facts, whether the Plan has agreed to that or not. Particularly in the Fifth Circuit, insurers are treated without question like trustees, and employees cannot sue for breach of contract and ever have a court resolve factual disputes on the merits if they disagree with an insurer's decision. The Fifth Circuit prohibits breach of contract suits on a *de novo* standard of review to resolve benefit eligibility disputes. And that is wrong.

The "practical reasons" the Fifth Circuit relied on to justify the deference given to denial-of-benefit decisions, when those decisions are contested by insured employees, should trouble this Court. The Fifth Circuit candidly stated these practical reasons in *Pierre*, first bemoaning the large number of claims that must be decided.[9] If courts reviewed *de novo* insurers' decisions denying employees' benefits and tried to decide which party was right, the

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[9]Between 1996 and 2000 (five years), 1,317,734 civil cases were filed in all federal district courts, of which 47,731 (3.6%) were ERISA cases. *2000 Annual Report of Director, Judicial Business of the United States.* ERISA cases constitute a small percentage of civil cases.

Fifth Circuit lamented, judges would become "resolvers of mundane and routine fact disputes."[10] *Pierre, 932* F.2d at 1559. This is not a good reason to adopt a rule that insurers' decisions are entitled to deference. If the insured personally purchased the insurance, rather than paying for it with a wage deduction at work or earning it by working for an employer, any dispute between the insured and insurer, while equally mundane, would have to be decided by a court based on true facts and impartial policy interpretation.

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[10] Chad Baruch, *The Widening Gyre: The Illusionary Promise of Meaningful Judicial Review of ERISA Benefit Denial In the Fifth Circuit*, 25 S.U. .L. REV. 99,116 (1997):

> The Fifth Circuit's focus on concerns of expediency and a potential litigation increase was misplaced. This very argument was rejected in Firestone. Firestone advanced the argument that employers would face more benefit challenges with higher costs , and might even be deterred from offering benefit plans. The Court disagreed by reiterating the ability of the parties to continually determine the standard of review. The Court also found this potential threat of litigation insufficient to warrant adoption of a deferential standard of review for all cases, stating that "the threat of increased litigation is not sufficient to outweigh the reasons for a de novo standard." Of course, the fear of a litigation flood is misplaced. Employers draft the plans and - so long as they comply with ERISA - can amend them to afford administrator discretion. More important, this argument would not - even if it were true - outweigh the need to protect ERISA beneficiaries. This protection is the central goal of ERISA, the very reason for its enactment. If inconvenience to employers is the cost of this protection, so be it (that is, in fact, largely the philosophy underlying ERISA).

Then there are *Pierre's* unabashed "considerations of expediency" that justify "deference to factual determinations made in the administration of the plan." *Id.*[11] If insureds could get federal trials to arrive at the truth, this would encourage "vast numbers of claims," "increase litigation," and "reduce the size of the fund from which benefits are paid." *Id.* One can hardly dispute, that if courts always defer to insurers' or their claims-adjustors' factual decisions, even if mistaken, the insurers' pot will grow, and the insureds, physicians, and hospitals will suffer from non-payment. But Congress imposed on federal courts jurisdiction over mundane ERISA claims. It is not for the courts to reduce the scope of their jurisdiction to resolve these disputes by creating a

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[11]Joseph Cunningham, *ERISA: Some thoughts on Unfilled Promises*, 49 Ark. L. Rev. 83, 90 (1996):

> The Fifth Circuit concluded that "expediency, therefore, forces courts to defer to the factual determinations of plan administrators." Expediency aside, it is far too artful to suggest that all such disputes over plan entitlements are either "mundane" or "routine." More to the point, plan administrators can hardly be considered disinterested adjudicators when their very employment depends on the severity of their claims handling practices. More often than not, the factual investigation by an insurance company staff is aimed at buttressing the decision to support administrative denial of the claim for benefits, with little or no evidence obtained from the participant - a participant who is usually unrepresented by counsel. This "kangaroo court" exercise then produces a report for the court's consideration which often instinctually wants no part of the claims-decision making process, and has ample precedent to avoid it. Only the employee, and justice, suffer.

substantive rule of law under which insurers almost automatically win, thereby discouraging claimants' lawsuits.

The ink was hardly dry on *Bruch* when *Pierre* was decided. There was no Plan in *Pierre*, just an insurance policy, insurer, and insured. ERISA was used to superimpose over the ordinary one-sided, insurer-insured relationship the dissimilar roles of insurer-trustee, insurance policy-plan, and insured-beneficiary. Trust law was applied to an insurance dispute to enhance the factual decision of the insurer to one entitled to deference by the courts. Worse still, this deference was due even though the plan contained no language agreed to by the employee-insured or employer-plan sponsor that reflected that as purchasers of this insurance they agreed the insurer's decision on benefits was to be deferred to when it came to deciding the facts. Nonetheless, the Fifth Circuit concluded: "we hold that for factual determinations under ERISA plans the abuse of discretion standard of review is the appropriate standard: that is, federal courts owe due deference to an administrator's factual conclusions that reflect a responsible and impartial judgment." *Pierre,* 932 F.2d at 1562. This should be reversed.

**III. The Extension of *Pierre* to Require Deference to Decisions of Those Disclaiming Any Fiduciary Role Under ERISA Nullifies the Role of Federal Courts In Deciding Disputes.** Those who represent and agree they will not act as plan administrators or fiduciaries for ERISA purposes should be taken at their word. In the documents they drafted, CBSA and Benchmark thought it in their interest to expressly require the employer to recognize that Benchmark and CBSA were not plan administrators or

fiduciaries for ERISA purposes.[12] They should not be able to reverse positions when it suits them. Nonetheless, defendants contended that all the documents in which CBSA and Benchmark disclaimed they were Plan administrators or fiduciaries for ERISA purposes were illegal in that regard and void, arguing that Benchmark and CBSA "may not exonerate themselves of fiduciary, responsibility. 29 U.S.C. § 1110(a)." (R.1093)

The trial court circumvented the effect of the disclaimers by declaring illegal and void the disclaimer that CBSA was not a fiduciary under ERISA, and accepting the Defendants "concession" that CBSA was a fiduciary. If the disclaimers by Benchmark and CBSA are illegal and thus void, the logical conclusion is that CBSA should have acted as a fiduciary toward the Plan and Tedford, not that it did act as a fiduciary toward the Plan and Tedford.[13] Cases in which courts have held

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[12]Professor Kathryn Kennedy reports that insurers and their adjustors may find disclaimers of fiduciary obligations beneficial:

> Even if a third-party administrator is used, the employer may decide to reserve the power to interpret provisions of the plan and to determine eligibility. In fact, third-party administrators not wishing to become fiduciaries may insist that such discretionary powers be reserved to the plan sponsor.

Kathryn Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases,* 50 Am. U. L. Rev. 1083, 1116 (1999); *see also, Reddal Indus. v. Wiegand*, 878 F.Supp. 1026, 1032 (E.D. Mich. 1995).

[13]CBSA was not a defendant, and no evidence was presented that it renounced its disclaimer of a fiduciary role, or that it acted as a fiduciary. On summary judgment the defendants should have been required to prove CBSA was acting impartially and fairly as a fiduciary toward Tedford. It was not enough to prove what CBSA said it would do was illegal for it to do. Just because it is illegal to steal cars does not mean there are no car thieves.

disclaimers void are ones where a suit was brought claiming the defendant was liable to the plan because of a breach of fiduciary duties and the defendant sought to avoid liability based on its disclaimer. *See IT Corp. v. Gen. Am. Life Ins. Co.*, 107 F.3d 1415 (9th Cir. 1997), *cert. denied, IT Corp.*, 522 U.S. 1068 (1998). Where one should act as a fiduciary, liability for breach of fiduciary duty cannot be escaped by disclaimer of the fiduciary role.

But not all disclaimers of the role of fiduciary are void. In *Wilkinson v. Haworth*, 186 F.Supp.2d 687 (S.D. Miss. 2002) the insurer's disclaimers that it was plan administrator or fiduciary were effective, because it made claims decisions within preapproved guidelines, and, like CBSA, did not exercise discretion over the Plan's assets. *See also, Reich v. Lancater*, 55 F.3d 1034, 1047 (5th Cir. 1995) (one whose disclaimer is "sufficiently limited by a preexisting framework of policies, practices and procedures" is not a fiduciary.) Where, as here, the only issue is whether a court should give deference to a claims-adjustor's decision, the thrice repeated disclaimer by that decision-maker, who had no discretion to approve the claim, that it was not an administrator or fiduciary for ERISA purposes, should be determinative. No deference should be given to its decision denying benefits.

An entity like CBSA, which has not been delegated discretion to independently and finally decide claims cannot be a plan fiduciary. *See Baker v. Big Star Div. of Grand Union Co.*, 893 F.2d 288, 290 (11th Cir. 1989). The duties a fiduciary has under ERISA § 404(a)(1) require that the fiduciary act in the interest of the participants and beneficiaries. The fiduciary shall insure that the plan is "for the exclusive purpose of: (1) providing benefits to participants and their beneficiaries." *See Clark*

*v. Washington Teamsters Welfare Trust*, 8 F.3d 1429, 1432 (9th Cir.1993). ERISA § 503(2) requires that the employee have the right to appeal the denial of benefits to "the named fiduciary." 29 U.S.C. § 1133 Where, as here, the entity deciding benefit eligibility is constrained by its agreement with the insurance underwriter not to approve large claims unless they are first approved by the insurer, then the decision-maker cannot be an ERISA fiduciary to plan participants. Its decision is not binding on the insurer, and should not be binding on the participant.

## CONCLUSION

The judgment below should be reversed. The case should be remanded to the trial court for further proceedings conducted in accordance with this Court's decision.

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